

# King Philip Regional High School – Daily Symptom Severity Scale Form

Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Page: \_\_\_\_\_ of \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ AM/PM

Symptom	None	Mild	Moderate	Severe			
Headache	0	1	2	3	4	5	6
Pressure in Head	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Like "In A Fog"	0	1	2	3	4	5	6
Don't Feel Right	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Fatigue or Low Energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total Number of Symptoms \_\_\_\_ / 22  
Symptoms Severity Score \_\_\_\_ / 132

If 100% Is Normal, What Percent of Normal Do You Feel? \_\_\_\_\_%  
Why? \_\_\_\_\_

Do Your Symptoms Get Worse with Physical Activity? Y N  
Do Your Symptoms Get Worse with Mental Activity? Y N

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ AM/PM

Symptom	None	Mild	Moderate	Severe			
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Trouble Falling Asleep	0	1	2	3	4	5	6
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Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

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